R E P O R T R E S U M E S

ED 015 500 CG 001 078

THE USE OF INDIGENOUS VOLUNTEERS IN A REHABILITATION LIVING UNIT FOR DISTURBED COLLEGE STUDENTS.

BY- SINNETT, E. ROBERT NIEDENTHAL, LINDA K.
KANSAS STATE UNIV., MANHATTAN, STUD.COUNSELING CTR

REPORT NUMBER REHAB-LIVING-UNIT-RR-1 PUB DATE SEP 67
EDRS PRICE MF-$0.25 HC-$0.96 22P.

DESCRIPTORS- RESEARCH, *COLLEGE STUDENTS, *VOLUNTEERS, RESIDENT ASSISTANTS, *RESIDENTIAL PROGRAMS, SUBPROFESSIONALS, DORMITORIES, STUDENT PROBLEMS, STUDENT REHABILITATION, *THERAPEUTIC ENVIRONMENT, *MENTAL ILLNESS,

THE USE OF INDIGENOUS VOLUNTEERS IN A REHABILITATION LIVING UNIT FOR DISTURBED COLLEGE STUDENTS IS DESCRIBED. VOLUNTEERS ARE OF BOTH SEXES AND INCLUDE LOWER- AND UPPERCLASSMEN WITH A DIVERSITY OF MAJORS. THEY LIVE IN A COEDUCATIONAL REHABILITATION UNIT WITHIN A RESIDENCE HALL WITH A POPULATION (CLIENTS) REFERRED BY COUNSELORS AND THE PSYCHIATRIC STAFF. TYPICALLY, VOLUNTEERS ARE FACED WITH PROBLEMS SIMILAR TO THOSE FACED BY CLIENTS BUT ARE ABLE TO DEAL MORE SUCCESSFULLY WITH THEM. VOLUNTEERS ALSO APPEAR TO EXPECT TO GAIN AS MUCH AS THEY GIVE TO THE PROGRAM. CLIENTS ARE NOMINATED BY COUNSELORS. MOST ARE FULL-TIME STUDENTS WHO CLINICALLY DO NOT APPEAR TO BE AS MANIFESTLY DISTURBED OR REGRESSED AS INDIVIDUALS ON PSYCHIATRIC WARDS. CLIENTS RECEIVE ALL CONVENTIONAL SERVICES, ARE ENCOURAGED TO HELP ONE ANOTHER, AND ARE ENCOURAGED TO BE HONEST, OPEN, AND CONFRONTING. THERE IS NO CASTE SEPARATION BETWEEN VOLUNTEERS AND CLIENTS AND BOTH RECEIVE THE SAME PROGRAM ORIENTATION. THE GROUP IS SELF GOVERNING WITHIN THE UNIVERSITY FRAMEWORK. THERE IS A WEEKLY TWO HOUR MEETING WITH PROJECT STAFF. INITIAL FINDINGS SHOW PROMISE FOR DECREASING THE DROPOUT RATE OF DISTURBED STUDENTS. CONSENSUS EXISTS AMONG BOTH VOLUNTEERS AND CLIENTS ABOUT THE RELATIVE VALUE OF THE THERAPEUTIC COMMUNITY AS A RESOURCE FOR TREATMENT AND MATURATION. (SK)

ED015500

Rehabilitation Living Unit
STUDENT HEALTH SERVICE
Kansas State University

Research Report #1

THE USE OF INDIGENOUS VOLUNTEERS IN A REHABILITATION LIVING UNIT FOR DISTURBED COLLEGE STUDENTS

E. Robert Sinnett, Ph.D. and Linda K. Niedenthal, B.A.

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL OFFICE OF EDUCATION POSITION OR POLICY.

September, 1967

CG 001 078

A Preliminary Note

The work reported in this paper was conducted while the project was administratively in the Student Counseling Center. Dr. David G. Danskin, Director, has generously afforded us the opportunity to circulate this paper under the auspices of the Student Health Service, our new site of operation.

Grateful acknowledgement is extended to those student volunteers who played such an important role in this pioneering rehabilitation effort.

E. Robert Sinnett

Abstract of

THE USE OF INDIGENOUS VOLUNTEERS IN A REHABILITATION LIVING UNIT FOR DISTURBED COLLEGE STUDENTS

E. Robert Sinnett, Ph.D. and Linda K. Niedenthal, B.A.

Indigenous volunteers may provide a supplementary source of help to their emotionally disturbed peers. Lowering the threshold of accessibility of professional staff for direct service to students and consultation with dormitory staff are also a part of this program. Initial findings show promise for decreasing the drop-out rate of disturbed students. There is a consensus among volunteers and clients concerning the relative value of the therapeutic community as a resource for treatment and maturation.

THE USE OF INDIGENOUS VOLUNTEERS IN A REHABILITATION LIVING UNIT FOR DISTURBED COLLEGE STUDENTS[1]

E. Robert Sinnett, Ph.D. and Linda K. Niedenthal, B.A.[2]

Campus services for emotionally disturbed students are relatively institutionalized. In a medium or large university one typically finds a psychiatric service in the student health service, a counseling center, or other student personnel programs for treating the student and/or dealing with him as a social deviant (e.g. the handling of disciplinary problems). These services are remarkably similar from one college setting to another.

The programs denoted above (psychiatric services, counseling centers, and student personnel services) are oriented toward treating the client who is sufficiently responsible and organized to come for regular interviews by appointment during office hours. However, just as a mental hospital's institutional structure impinges on patients (Goffman, 1961), these campus services for the disturbed student have an institutional press which affects clients and defines those who are treatable.

In order to receive treatment the student must conform to the practices and procedures of the agency in manifesting his disturbance and using its facilities. Also there are definite spatio-temporal boundaries for receiving services. Within this structure, the emergency role can be used by the student who is chronically and severely disturbed or by the student in crisis. This role, however, is conceived of as a temporary one which a student may use infrequently. For convenience let us refer to this set of practices and procedures as the treatment system.

While the varied services of the treatment system are helpful and sufficient for the needs of most students, both the university social system and the treatment system have definite inherent limitations concerning who can be tolerated and hence served within the existing structure of the university community. It is our contention that there is a significant number of students who are unable to conform to the requirements of the treatment system and who might be helped by using a different model of rehabilitation or treatment. The schizophrenic, the very immature individual, and the acting-out student may be among those who cannot be treated within the usual treatment system.

Three years ago the staff of the Counseling Center at Kansas State University (Sinnett, Friesen, Danskin, Kennedy and Wiesner, 1966) began to plan a departure from the treatment system which would enable us to help the more severely disturbed students. The use of the living unit appeared to be a promising but neglected resource. Although there had been widespread use of halfway houses and milieu therapy approaches for treating psychiatric patients, college residence halls had not heretofore been considered for their rehabilitative and therapeutic potential. Both the halfway house and the therapeutic community model influenced our plans considerably[3]. However, neither of these approaches could be directly and unimaginatively transposed to a college setting. Considerable modification, exploration, and trial were needed to utilize the principles of these methods. A general description of our program has been published elsewhere (Sinnett, Wiesner, and Friesen, 1967). Our aim in this paper is to describe in some detail one of the key differences between our program and those of the halfway house and the therapeutic community: namely, the use of the indigenous college student volunteer.

The literature on college student volunteers shows that they have been used in a variety of ways: as aides in a mental hospital (Kantor, 1957),

as visitors, companions, and sources of support to inpatients (Greenblatt and Kantor, 1962; Umbarger, Dalsimer, Morrison, and Breggin, 1962), and as contacts and supports to people in the community who are disabled, disturbed, and readjusting to the community after dismissal from an institution (Fisher, Beard, and Goertzel, 1960). While many programs have concentrated on adult patients, there have also been programs using college student volunteers to work with children (Cowen, Zax, and Laird, 1966; Mitchell, 1964; and Reinherz, 1963).

A relatively novel use of college student volunteers is in the Wellmet House program (Bennett, 1964; Kantor and Greenblatt, 1962) where Radcliffe and Harvard students live with ex-psychiatric patients and attempt to help them. In this program the volunteers, a resident director, and ex-patients reside in a house which is managed and maintained by the cooperative efforts of all the residents. A small staff of consultants is regularly available as well as on call. The students provide social and emotional support and stimulation while encouraging the former patients to establish themselves in jobs, families, and more demanding and fulfilling roles in the community.

One new method of utilizing volunteer services is the introduction of indigenous, non-professional workers (Brager, 1965; Grant, 1965; Levinson and Schiller, 1966; Reiff and Riessman, 1965; and Riessman, 1965). This approach involves using volunteers or personnel from the group or community which needs help rather than bringing in and using staff from another group or area. There are several advantages in using indigenous non-professionals. One result has been an increased ability or ease on the part of those seeking help to relate to and receive assistance from a volunteering peer rather than from an outsider. Since the indigenous worker is from the group needing assistance, he is typically in need of some of the same resources. It has been found that the indigenous worker who has volunteered is not only more aware of and receptive

to the assistance available, but frequently receives support and assistance from the role itself.

Our use of college student volunteers living in residence with clients is similar to that of the Wellmet program except that both volunteers and clients are students.

The Volunteer

In our program normal college student volunteers of both sexes were nominated by student personnel workers (residence hall directors, counselors, and deans) and interviewed by one or more of our project staff and selected for inclusion in the program. These students volunteered to live in a coeducational rehabilitation living unit within a university residence hall with a client population referred by counselors and psychiatric service staff. For volunteers no selective criteria with respect to class, grade-point-average, or major were imposed. Initially we found ourselves inclined to choose upperclassmen but we felt that such a selection might create an undesirable social distance between volunteers and clients. We also decided to have diversity in majors for we did not wish to have primarily preprofessional individuals who would see themselves as "junior therapists".

Our initial conception was that the volunteers were to be role models: good students and examples of good adjustment. Both clients and volunteers rejected this designation because of its connotation of being an ideal. It seemed that being a model may be artificial in a natural living setting as opposed to a treatment setting where there are many supports and sanctions for maintaining well-defined occupational roles and status relations among treatment personnel and patients. In practice the volunteers were sought as helpers and their superior coping with the problems of the college years often served as a model for clients.

Only one candidate who sought to be a volunteer in our program was obviously ill. Most of the volunteers chosen seemed to have a genuine interest in community service. Since the selection process did not involve an assessment of personality dynamics, some moderately disturbed individuals were selected. Many who volunteered were frank in declaring their interest in developing a greater understanding of themselves and others. Consultation with professional staff and a weekly meeting of all project members were available for these purposes. Increasingly this group meeting has taken on a human-relations or T-group orientation in which it is recognized that all individuals have problems and can profit by sensitivity training and the development of human relations skills.

Initially we felt that some inducement was needed to attract volunteers. Therefore we decided to pay the volunteers $25.00 per month for their participation in the project and to give them the title of Resident Fellow. At the outset a number of the volunteers declared that pay was unnecessary and that it actually created some problems: the volunteers seemed to feel guilty about receiving remuneration since they had no defined job; some of the clients felt anger toward volunteers who "didn't do anything"; and several clients who were very helpful to others felt that they should also be paid.

Prior to our second semester of operation we arrived at what has been received as an equitable solution: both groups are paid at the rate of $1.25 per hour (the current minimum wage) for the time which they spend participating as research subjects (taking tests, structured interviews, etc.). We have had no complaints from either subgroup with this payment procedure.

A prestigeful title (Resident Fellow) also proved to be unnecessary and undesirable. It seemed to create a status difference which produced social distance. We have dropped this in favor of "project member" as our most

frequent public designation for both groups. At times, however, we do use the titles "volunteer" and "client" or "referral".

The volunteers in the project fit into two general categories as defined by other researchers. First, they qualify as indigenous non-professionals as defined by Reiff and Riessman (1965). They are students and are faced with problems similar to those faced by clients, although problems encountered by volunteers are typically dealt with more successfully and are often less severe. Second, the volunteers fit rather closely into the existentialist style as defined by Gelineau and Kantor (1964) in that the volunteers do receive and often expect to gain as much as they give. They are usually impelled to reflect upon themselves more honestly and frequently gain in coping ability as a result of helping others deal with problems.

The Client

Kansas State University has increased in size from approximately 10,000 to 11,000 students during the course of this study. Also, a Psychiatric Service has been added this past year. Prior to this, the Counseling Center and the Student Health Service were the principal formal resources for helping the emotionally disturbed student.

In order to estimate the need for the rehabilitation living unit, counselors were asked to nominate candidates for whom they felt the additional assistance provided by a rehabilitation living unit would be desirable; i.e., they were to indicate which of their clients would need more than the services conventionally available in order to progress and maintain themselves in the university community. The annual caseload of the Counseling Center has been approximately 1,000 cases. Out of this population approximately 50 students have been nominated each year during the 1963-64, 1964-65, and 1965-66 academic years. As a result of the advent of the Psychiatric Service and awareness of the living unit as a resource,

the 1966-67 academic year (including a projected estimate for the summer) will probably yield about 70 cases. Thus the incidence of this group of disturbed students has been a relatively stable 5 to 7 per cent of the caseload of the Counseling Center and the Psychiatric Service over a three-year period. Since our project is located within a residence hall only single students have been nominated, so nomination is only a rough index of severity. Most of the clients were enrolled as full-time students and clinically they did not appear as manifestly disturbed or regressed as individuals commonly observed in halfway houses or on psychiatric wards.

In a study of one of the earliest groups of nominees, performance on the American College Test, a test of academic aptitude, showed the nominee group to be of average ability when compared with the norms for Kansas State University students. The drop-out rate for nominees was quite high: approximately 50 per cent per year (the normal drop-out rate at Kansas State University is 48 per cent over a four-year period).

In three semesters of operation we have served 28 clients; the diagnostic composition of the group may be seen in Table 1. Prior to entering the living

Table 1

Diagnostic Composition of Client Group

Diagnostic Categories	N	%
Schizoid personality	6	21.4
Schizophrenia*	13	45.4
Psychoneurosis	4	14.3
Personality trait disturbance	4	14.3
Adjustment reaction of adolescence	1	4.7
	28	100.1

*Includes borderline schizophrenia

unit, only four of the clients had been hospitalized in a psychiatric hospital and of these, two had had more than one hospitalization. Many more had had one or more brief hospitalizations in the Student Health Service for essentially psychiatric reasons, and many had received psychotropic drugs at some time while being a student.

The client population, except for degree of disturbance, has been composed of students from all class and ability levels and appears in other respects to be similar to students in general.

The Treatment Program

Our clients in the living unit receive conventional services: all are receiving counseling or psychotherapy. In addition, consultation from the psychologists on the project staff and medical and psychiatric consultation are readily available to them and the residence hall staff as needed. Although we provide some additional dormitory staff, we have no mental health professional persons in residence. The same direct and consultative services available to clients can be used by volunteers as needed.

Our living unit differs from the social system and the treatment system of the university community. With respect to the social system, students are encouraged to help one another and to be honest, open, and confronting. In the ordinary residence hall, deviant behavior is often responded to with rejection, hostility, anxiety and withdrawal of interest by fellow students or residence hall staff. Although the volunteers are not immune to these modes of response, their threshold is higher and they strive to deal constructively with the clients and their own feelings toward them.

A therapeutic community such as ours differs from that of the treatment system in many respects, some of which have been well described under the rubric of amicatherapy (Mitchell, 1966). Unlike the professional members of

the treatment system our student helpers have no distinctive dress, status, title, and there are no socioeconomic differences between groups. As one volunteer stated:

> "Perhaps the distinction between clients and volunteers has appeared to be quite precise. However, in actual living within the project, this is not the case. Each individual is aware of his own position, but is not necessarily aware of each other person's designation. While this is sometimes relatively apparent, at other times there is no obvious, behavioral distinction between the two categories. A volunteer is not always a 'helper' nor is a client consistently receiving help. There is no real status difference in functioning either as a client or as a volunteer. Each person is aware that at times he has problems, some of which he can handle more effectively than others. Likewise, some individuals can consistently handle situations more effectively than other students can. However, both of these statements refer to any individual in the project, not to persons in one group or the other."

The uninformed observer seeing our disturbed students might not discriminate them from volunteers in the living unit, or students in general in the dining hall, recreation areas, and other parts of the dormitory. Similarly, both volunteers and clients have held jobs in food service, housing, in the mail room and at the switchboard. Both groups have held offices in residence hall government and have participated in hall social functions. There is no caste separation between client and volunteer regarding friendship, dating, or sources of help sought. Unlike staff in the treatment system, fellow project members are available evenings, after closing hours, and on weekends.

Both the volunteers and the clients receive essentially the same orientation into the program. Each student who is planning to move into the project is given a tour of the physical arrangements and building. He is also told how many students are involved, where he will be living, and that he is expected to cooperate in certain research requirements, such as testing, meetings, and structured interviews. No definition of role is given the volunteer or the client and if questions are raised regarding a role, the student is usually told to be a "typical" roommate and to "be himself", or is encouraged to discuss the

interpersonal problem of concern to him with a staff person or in the large group meeting.

Our 20 to 24 project members have a weekly two-hour meeting with project staff. This meeting is used to initiate and maintain the atmosphere of the therapeutic community within the rehabilitation unit. The focus is on problems in group living and the orientation is much like that of a T group (Bradford, Gibb, and Benne, 1964). Students are encouraged in their efforts at self-understanding and understanding of others, and efforts are directed at sensitizing students as to how they impress others, how this may conflict with their intentions and needs, and, in general, how to deal actively with here-and-now interpersonal relations.

The group also serves as a self-governing body within the framework of university regulations. It has been an active agent in formulating rules for coeducational living, and it has replaced the hall judicial board for the handling of disciplinary problems involving group members. These functions are conducted in accordance with the philosophy of the therapeutic community.

In addition to the benefits for clients, we have chosen to use this group meeting as our source of training for volunteers rather than to offer the volunteers an intellectual approach to understanding, or to confer some quasi-professional status upon them which might estrange them from the clients. Admittedly the absence of a more structured training program has been a source of concern to the volunteer, but we have felt the disadvantages of a formal training program militate against it. The students are encouraged to confront each other and to maintain feedback during the week as well as at the meetings. Thus a student who is missing classes or having difficulty maintaining his appearance may be confronted frequently by one or more project members. This emphasizes the importance of individual relationships and increases the realization that one's behavior does affect and concern others. In this

function, the group members are actively implementing individualized treatment programs.

In summary, the role of the volunteer in the treatment process is one of relatively constant, intense involvement, but is also largely undirected although consultation with residence hall and professional staff is available. Some of the volunteers do have professional aspirations toward a career in the field of mental health, but they are in the minority. On the whole, these are students who have a non-professional view of the treatment process. The volunteers do not identify with professionals or with the agency, but tend to identify with the clients and see themselves as members of a group with problems to solve.

The Volunteer Experience

At the outset the absence of the well-defined social structure of the treatment system is commonly a source of concern to the volunteer. Since there are no specific duties or well-defined expectations, they wonder what they should do and how satisfactory their performance is. Often they experience some disappointment or frustration at the failure of their characteristic influence techniques to produce an immediate tangible change in their troubled peers. Rigid, unreflective individuals have become anxious when their usual defenses and interpersonal styles are ineffective and when they are confronted by other project members.

Some of our volunteers who had had prior sub-professional experience in social service entry occupations (Peace Corps, Neighborhood Youth Corps, and halfway houses) or positions of leadership seemed to find interference rather than benefit from their background. These individuals and others who conceived of themselves as offering help in the manner of a professional person

found their efforts rejected. The clients strived to maintain an egalitarian relationship rather than a subordinate one.

A persistent concern among volunteers is that of how involved they should be with a client's problems. A number of volunteers experience conflict between their commitment to helping clients and their own needs for privacy, study, personal gratification, and participation in the normal experiences of college life. The intensity of demands on the volunteers' resources requires that the staff be willing not only to offer consultation, but to provide nurturance and assurance that the volunteer is performing well at a worthwhile service. Even with these measures we have observed what Reiff and Riessman (op. cit.) have referred to as the "burn-out" phenomenon after one or two semesters of participation as a volunteer. In these instances one must attempt to differentiate genuine decline of interest from unresolved conflicts or an aversive response to anxiety. Although volunteers may become satiated with the experience of living with clients, most of them seem to have an enduring interest in mental health and some evolve or affirm an interest in a social service entry occupation or career.

The problems enumerated above constitute some of the major difficulties encountered by volunteers. These experiences are remarkably similar to those of the beginning student in a mental health profession and those reported by participants in T groups and individuals beginning psychotherapy. This parallel may be extended further: the anxiety and discomfort experienced is generally felt to be more than offset by the gains in self-understanding and personal growth as well as the satisfaction of having helped others.

The history of one volunteer in the living unit illustrates some common experiences:

Bill was a second semester freshman when he entered the project. He lived in the residence hall prior to the establishment of the project on the first floor of the hall. He made attempts to demonstrate his social leadership in the residence hall and admits that this desire to be a leader was part of his original motivation. He was also curious as to what the project would be like and interested in finding out more about himself. During his first semester in the project he displayed needs for acceptance and recognition of his ideas and abilities by frequent talking at meetings, dominating conversations, and by proposing social functions.

He stated that he had expected more direction by and contact with the project staff. However, he later realized that the staff wanted the group to establish its own direction and was willing to provide consultation and support to individuals as it was needed or suggested. Also, he discovered that even professional staff had no influence techniques which would produce instant benefits for clients.

Bill felt that he gained a great deal from being a volunteer. During his second semester in the project he was involved in an auto accident which was anxiety-producing in part because of being faced with a disfuguring injury. He changed his approach (not without difficulty, however) from that of being, in his words, "a benevolent important godfather" to accepting himself as one of the group with problems of his own. He realized his need for recognition and understood that he no longer needed to be a dominant leader, but could be influential and satisfied by being one of the group. Personal counseling which he sought on his initiative gave him insight into his dependency on others for approval and led to greater self-acceptance. As a consequence of these various changes, he was able to reduce his talkativeness and activity and become a better listener and observer.

Bill feels that his experience in the project gave him greater insights into people and mental illness than some of his classroom education. He stated that living in the project gave him a more realistic as opposed to an intellectual appreciation of others.

During his third semester in the project and following his period of intense anxiety about himself, Bill decided that he was ready to leave the project and demonstrated aspects of the burn-out phenomenon. He still maintained an interest in his roommates and close friends and associates, but didn't want or need to become so involved in everyone's problems. He still has an orientation toward social activities and working with people, but no longer needs to present a domineering "godfather" image in order to get response, recognition, and acceptance. He is more realistic about himself, his own needs and goals, and his abilities to be interested and involved in the problems and lives of other people.

Effectiveness of the Program

Since this is a report of research in progress, only some preliminary impressions can be offered.

The academic drop-out rate has been relatively low in our client group; thus far only four of twenty-eight students are known drop-outs. Although this figure is low when compared with the rate found in the years prior to the advent of our program, the interpretation of this finding is complicated by the fact that those nominees who have participated in control testing only (not as residents of the living unit) also have a relatively low attrition rate. However, nominees who do not participate as members of the control group maintain a high attrition. There may be differences in motivation for help or severity of disturbance among these subgroups. Further examination and comparisons of data from the nominees who do not participate as controls, the controls, and the experimental groups are in progress.

From the standpoint of the subjective evaluation of students, the group living experience is highly valued. When asked to rank the psychological sources of assistance available to them from most to least helpful, the category "informal contacts with project members" has consistently ranked as first or second of five or six alternatives throughout the three semesters of operation by both volunteers and clients.

The alternatives for the first and second semesters were: (1) informal conversations with project members; (2) large group meetings; (3) meetings with subgroups around special problems; (4) consultation with professional staff; and (5) counseling appointments. The alternatives for the third semester, when this program was slightly modified, were the same except that the third and fourth were omitted and small group meetings, periodic interviews and staff conferences were added. For the volunteers only and for combined comparisons of volunteers and clients, the counseling appointment alternative was omitted. The agreement

among clients, volunteers, and combined groups ranged from coefficients of concordance (W) of .56 to .72, and all W values were statistically significant beyond the .05 level of confidence (see Table 2). These data show

Table 2

Agreement of Rankings of Sources of Help among Clients (C), Volunteers (V), and Clients and Volunteers Combined (C & V)

	Spring 1966			Fall 1966*			Spring 1967		
	C	V	C & V	C	V	C & V	C	V	C & V
W	.52	.56	.57	.56	.70	.72	.68	.68	.59
m	5	4	4	5	4	4	6	5	5
N	8	10	18	4	4	8	15	9	24
p**	.02	.02	.01	.01	.05	.01	.001	.001	.001

*Only those leaving the unit were included as subjects in the Fall of 1966 so as to reduce interdependence of the data by semesters. The overlap between groups is as follows: one client appeared in both Spring and Fall 1966 samples; four volunteers and one client were in the two Spring groups.

**P values were determined by chi-square technique except when N<7. For N<7, tabled probability values were used (Siegal, 1956).

a statistically reliable agreement among the rankings of each of the subgroups. Overall ranks of the modes of help show that for the first semester, informal contacts with others were even more highly valued by clients than their counseling appointments. In subsequent semesters counseling was judged most helpful, and the informal contacts with peers were second in importance.

Clinically, clients in this setting show improvement which appears to be a product of the rehabilitation living unit climate and interpersonal relations. Only one paranoid schizophrenic individual thus far has seemed to show increased disturbance as a result of the intensity of the small group experience.

His period of distress seemed to be episodic and not unlike those experienced by him earlier and subsequently.

A case[4] which illustrates the use of the unit as a rehabilitative resource is as follows:

> Harold first sought psychiatric treatment at the suggestion of his attorney while he was charged with driving while intoxicated and had indicated thoughts of suicide. He exhibited much tension, suppressed hostility, feelings of inadequacy, guilt, awareness of chronic unhappiness, and showed marked inhibition in expressing himself; he was very isolated socially.
>
> He was seen for psychotherapy interviews once or twice a week for three months and then suffered a brief episode of aggressive behavior while drinking. He was apprehended by campus police and hospitalized for three weeks in a psychiatric hospital. Psychological testing and the hospital staff's evaluation was that he was not psychotic but schizoid in personality traits, rigid and unable to express hostile feelings. The hospital staff saw "definite strength in his intellectual ability, capacity for organizing material, and ability to go ahead on his own with projects he starts."
>
> The student returned to outpatient psychotherapy and entered the rehabilitation living unit where he came to feel accepted by the group and made significant gains in his social adjustment. He seemed to quietly enjoy the opportunity for casual association with male and female project members at meals and in the lounge, and he showed a new warmth and comfort in his interviews. He made two very close friends with men in the project -- one a volunteer and one a client. He had an equally impassioned covert dislike for some of the other men. He had at least two open episodes of drunkenness and during one of these his friends were concerned; they searched for and found him in order to save him from trouble. On another occasion he seemed to be testing people's acceptance of him with verbal aggression and pounding with his fist on a metal ash tray. He rarely attended the group meetings and refused to participate in some of the research activities. He often kept to himself by saying he was "busy". This kind of non-conformity which he showed in the group seemed much more within the bounds of socially acceptable conduct.
>
> He terminated psychotherapy and left the living unit after one semester. After one more year of college he graduated. When seen for an informal follow-up interview just prior to graduation he seemed quite relaxed, open, and self-accepting, and was seeking a commission in the armed forces.

Counselors and Psychiatric Service staff have come to view the living unit as a significant resource to be used in conjunction with conventional services and as an alternative to psychiatric hospitalization. We have come to feel that we can help seriously disturbed students maintain themselves and progress within the university community.

REFERENCES

Bennett, W.I. Students, patients share halfway house. Rehabilitation Record, 1964, 5, 21-23.

Bradford, L.P., Gibb, J.R., & Benne, K.D. (Eds.). T-group theory and laboratory method. New York: Wiley, 1964.

Brager, G. The indigenous worker: a new approach to the social work technician. Social Work, 1965, 10, 33-40.

Cowen, E.L., Zax, M., & Laird, J.D. A college student volunteer program in the elementary school setting. Community Mental Health Journal, 1966, 2, 319-328.

Fisher, S.H., Beard, J.H., & Goertzel, V. Rehabilitation of the mental hospital patient: the Fountain House Programme. International Journal of Social Psychiatry, 1960, 5, 295-298.

Gelineau, V.A., & Kantor, D. Pro-social commitment among college students. Journal of Social Issues, 1964, 20, 112-130.

Glasscote, R.M., Sanders, D.S., Forstenzer, H.M., & Foley, A.R. Prairie View Hospital and Fort Logan Mental Health Center. In The community mental health center. Washington, D.C.: American Psychiatric Association, 1964, 121-132 and 133-148.

Goffman, E. Asylums. Garden City, New York: Anchor Books, Doubleday & Company. 1961.

Grant, Joan. Industry of discovery. In A. Pearl & F. Riessman, New careers for the poor. New York: Free Press, 1965, 93-124.

Greenblatt, M. & Kantor, D. Student volunteer movement and the manpower shortage. American Journal of Psychiatry, 1962, 118, 809-814.

Kantor, D. The use of college students as "case aides" in a social service department of a state hospital. In M. Greenblatt, D.J. Levinson, & R.H. Williams (EDS), The patient and the mental hospital. Glencoe, Illinois: Free Press, 1957, 603-608.

Kantor, D. & Greenblatt, M. Wellmet: halfway to community rehabilitation. Mental Hospitals, 1962, 13, 146-152.

Levinson, P. & Schiller, J. Role analysis of the indigenous nonprofessional. Social Work, 1966, 11, 95-101.

Mitchell, W.E. Fictive siblings and the "unworthy" child in changing rural Vermont. American Journal of Orthopsychiatry, 1964, 34, 265-266 (Abstract).

Reiff, R. & Riessman, F. The indigenous non-professional: a strategy of change in community action and community health programs. Community Mental Health Journal, No. 1, Monograph Series, 1965.

Reinherz, Helen. College student volunteers as case aides in a state hospital for children. American Journal of Orthopsychiatry, 1963, 33, 544-546.

Riessman, F. "Helper" therapy principle. Social Work, 1962, 10, 27-32.

Rothwell, Naomi D., & Doniger, Joan M. The psychiatric halfway house. Springfield, Illinois: Charles C. Thomas, 1966.

Siegel, S. Nonparametric statistics. New York: McGraw-Hill, 1956.

Sinnett, E.R., Friesen, W.S., Danskin, D.G., Kennedy, C.E., & Wiesner, E.F. Should the halfway house go to college? American Journal of Orthopsychiatry, 1966, 26, 308-309.

Sinnett, E.R., Wiesner, E.F., & Friesen, W.S. Dormitory halfway house. Rehabilitation Record, 1967, 8, 34-37.

Umberger, C.C., Dalsimer, J.S., Morrison, A.P., & Breggin, P.R. College students in a mental hospital. New York: Grune & Stratton, 1962.

FOOTNOTES

[1]The research and demonstration project on which this report is based is supported in part by a grant from the Vocational Rehabilitation Administration, Department of Health, Education, and Welfare (RD-2053-P-67-C1).

[2]Dr. Sinnett, a clinical psychologist, is Director of the Rehabilitation Living Unit, Assistant Director of the Counseling Center, and Professor of Psychology at Kansas State University, Manhattan, Kansas. Miss Niedenthal, a sociology graduate, was a participant observer for the project and is currently on the staff at Woodley House, Washington, D.C. The authors gratefully acknowledge assistance from Mr. Paul Ruth, a former participant observer, and from Mr. John Eger and Mrs. Ann Kugler, former volunteers, in the preparation of this paper.

[3]In particular the programs of Wellmet House (Bennett, 1964) and Woodley House (Rothwell and Doniger, 1966), Ft. Logan Mental Health Center (Glasscote, Sanders, Forstenzer, and Foley, 1964) and Prairie View Hospital (Glasscote *et al*, *op. cit.*) were a valuable source of ideas for us.

[4]This resume was adapted from a report by B.S. Lacy, M.D., Consulting Psychiatrist.